

Urology OHIP Billing Cheat Sheet 2026

OHIP specialty 35 · Office cystoscopy · Office procedure · Called to ED or ward · Updated October 2026

Interactive version: <https://verismo-apex.com/resources/ohip-billing-cheatsheet/urology>

Pick the visit, tick what you did, bill the codes at the bottom. Ontario fees effective July 1, 2026.

Office consultation

A355A	Consultation Written referral from a physician or NP; written report back. Includes the GU exam and, when needed, urethral calibration, catheterization and prostatic fluid exam (A207). Limit: 1 per patient per 2 years for the same diagnosis (GP17).	\$93.15
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart review. Chart start and stop times (GP19–GP20).	\$194.65
A356A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	\$64.90

- 50+ minutes face to face? A935A pays \$194.65, more than double A355A (\$93.15). Procedure time and charting don't count (GP19–GP20).
- The consult does not include endoscopy: a cystoscopy you decide on and do today is paid on top (A207, SP4 §13).
- Catheterization and prostatic fluid exam at the consult are included; don't bill Z611A or G476A with it (A207).
- A second consult for the same diagnosis within 2 years is paid as a specific assessment, unless it's a repeat consult or an in-patient/ED consult 12–24 months later (GP17).

Office follow-up

A354A	Follow-up visit History of the problem, the exam needed, advice. Partial assessment.	\$30.60
A353A	Full work-up of one problem Full history of the complaint and detailed GU exam. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	\$51.45

- Your office has no specific re-assessment code: routine follow-ups are A354A. A353A is limited to 1 a year per patient (2 for a clearly different diagnosis) (GP23).
- Doing a planned Z-code procedure today (cystoscopy, prostate biopsy) that you decided on at an earlier visit? A354A is the only visit payable before it (SP4 §13).
- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Changing a suprapubic tube is billed as a visit, not a procedure (T6 §2).
- E078A (chronic disease premium) isn't payable to urology (35): GP25 limits it to geriatrics, endocrinology, neurology, paediatrics, pathology, physical medicine, radiation oncology, medical oncology, infectious disease, respirology, rheumatology, haematology and clinical immunology, so OHIP won't pay it.

Office cystoscopy

Z606A	Cystoscopy Diagnostic, with or without urethroscopy (T7).	\$77.00
Z607A	Repeat cystoscopy within 30 days	\$38.05

- Every E add-on you did is paid on top of the cystoscopy: biopsy E776A, fulguration E781A, stone or foreign body removal E789A, retrograde E817A (T6 §4, T7).
- No extra claim for an exam under anaesthesia, for female urethral dilatation, or for male dilatation unless stricture is the main diagnosis (T6).
- Catheterization (Z611A) isn't paid with a cystoscopy or any other surgical procedure (T8).
- Decided on the cystoscopy at today's consult? Bill both. Decided at an earlier visit? Only A354A can go before it today (SP4 §13).
- A pre-op consultation done only to prepare a patient for cystoscopy under local or IV sedation is paid only when the chart shows it was medically necessary (GP18).

Office procedure

- Vasectomy in the office: S626A + E545A = \$128.85 (U6). The visit where you decided on it is paid separately (SP2).
- Transperineal prostate biopsy adds E821A (\$20.00) to Z712A (U8). Ultrasound guidance J149 is paid to one physician only (G11).
- Catheterization is only paid for acute retention, a Foley or SP tube change, or instillation, done personally (T8).
- BCG or chemo instillation Z610A includes the catheterization; no Z611A on top (T8).
- PVR by ultrasound (G900A) goes with uroflow (G475A) but not when you do a cystometrogram, voiding pressure study or G192A–G194A (J115).

Called to ED or ward

A355A	Consultation Requested by the ED or ward physician. Written report.	\$93.15
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	\$194.65
A356A	Repeat consultation Same problem, new request, after another physician's care in between.	\$64.90
A353A	Full work-up, your own patient Specific assessment.	\$51.45
A354A	Brief assessment Partial assessment.	\$30.60

- Use A-prefix codes plus the premiums when called in non-electively, not C-codes (GP43, GP65).
- The premiums shown are the ED table (I). For an in-patient on a ward (table III, C9xx) or an out-patient clinic (table II, U9xx) the amounts are the same; bill that table's codes (GP71–GP72).
- No premiums for patients you see on rounds or for elective admissions (GP65).
- Took the patient to the OR? Pick Emergency surgery for the operation and E409A/E410A (SP2 \$2).

In-patient consult

C355A	Consultation Requested by the attending physician, routine (not a called-in visit).	\$93.15
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	\$194.65
C356A	Repeat consultation	\$64.90
C353A	Full work-up Specific assessment.	\$51.45
C354A	Re-assessment Specific re-assessment. Pays less than a C352A subsequent visit.	\$29.35
C358A	Concurrent care You keep following the patient while another physician is the MRP. Limit: 4 in week 1, then 2 a week (GP48).	\$31.60

- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2, GP40).
- Elective surgical admission and you did a pre-op assessment in the last 30 days: no admission assessment (GP41).
- Called in urgently instead? Use the ED or ward tile for A-codes and premiums.
- Concurrent care is 4 claims in the first week and 2 a week after; it never takes E083A (GP47–GP48).

Hospital rounds

C122A	Day after admission, you're the MRP Once per admission (GP44).	\$71.80
C123A	Second day after admission, you're the MRP Once per admission (GP44).	\$71.80
C142A	First visit after transfer out of ICU, you're the MRP Patient was getting critical, ventilatory or comprehensive care, not just monitoring, and you didn't give that care. One of C122A or C142A per admission (GP46).	\$71.80
C143A	Second visit after transfer out of ICU, you're the MRP Same conditions. One of C123A or C143A per admission (GP46).	\$71.80
C352A	Routine daily visit 1 a day in weeks 1–5; then C357A (3 a week) and C359A (6 a month) (GP43).	\$31.60
C124A	Discharge day, you're the MRP Stay over 48 hours; discharge summary within 48 hours (GP45).	\$71.80
C126A	Discharge day, complex patient Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes (A13).	\$95.10
C121A	Extra visit for an acute intercurrent illness After week 5, when the weekly or monthly limit is used up; the limits don't apply to it (GP43).	\$40.05

- As MRP after surgery, C122A and C123A pay \$71.80 instead of \$31.60 for the first two days (GP44).
- E083A adds 30% to your MRP visits; surgeons qualify (GP47). The E084A weekend premium is not open to Urology (GP47).

- Post-op visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Patient came to your ward from the ICU? C142A and C143A pay \$71.80 for your first two visits, in place of C122A/C123A; not if you gave the critical care (GP46).
- Palliative patient you're MRP for: C982A (\$40.05) per visit, and E083A applies to it (GP47, GP50). Concurrent care C358A is in the In-patient consult tile.

Booked surgery (OR)

Z628A	Ureteroscopy Cystoscopy and diagnostic ureteroscopy above the intramural ureter. Add stone, laser and upper-tract codes below (T4).	\$125.70
Z632A	TURBT, single tumour 1–2 cm Cystoscopy is included (T8).	\$290.90
Z633A	TURBT, tumour over 2 cm or multiple Multiple tumours: bill Z634A, same fee. Cystoscopy included (T8).	\$468.70
S655A	TURP Endoscopic removal or destruction of prostate tissue. Redo within a year by you: S654A (U8).	\$483.05
S639A	Laser enucleation of the prostate (HoLEP) Includes morcellation (U8).	\$550.00
S651A	Radical prostatectomy Includes vasectomy, bladder neck repair, vesiculectomy; not investigative cystoscopy (U8).	\$1,174.70
S416A	Nephrectomy Nephroureterectomy: S420A (\$1,336.35) (T2).	\$972.35
S411A	Partial nephrectomy T2.	\$972.35

- Ureteroscopy add-ons stack on Z628A: stone removal E760A (\$174.55), laser lithotripsy E761A (\$100.75), upper third or renal pelvis E822A, second ureter E819A (T4).
- Laparoscopic or robotic radical prostatectomy, nephrectomy or partial nephrectomy: E792A adds 25% (T2, U8).
- No cystoscopy claim when you resect bladder tumours (T8).
- The decision-to-operate visit is always billed separately, whenever it was. The day-surgery or admission assessment isn't, unless it was that visit (SP2).
- Second procedure under the same anaesthetic: 85% of its fee, unless both are Z-codes, which are each paid in full (SP2 \$3, SP4 \$13).

Emergency surgery

S600A	Testicular torsion: reduction and orchidopexy One or both sides (U3).	\$456.95
S470A	Cystoscopy with stone manipulation or removal Retrograde pyelogram included if done (T3).	\$240.65
Z606A	Cystoscopy (e.g. stent for an obstructed kidney, clot evacuation) Add the stent or clot code below.	\$77.00
Z786A	Priapism: aspiration, irrigation and injection Not paid if followed by a shunt or other penile surgery for the same episode (U1).	\$250.00
S582A	Penile fracture repair	\$650.00
S595A	Ruptured testicle repair U3.	\$448.70
Z608A	Manual catheter declotting and bladder irrigation	\$58.65

- Bill the ED consult (with its travel and first-person premiums) from the Called to ED tile; it's payable with the emergency procedure (SP2 \$2).
- Started 17:00–24:00 weekdays or any time on a weekend or holiday: E409A +50%; 00:00–07:00: E410A +75% of the procedure fee (GP104).
- Elective case pushed into the evening by an emergency still earns E409A/E410A (GP103–GP104).
- E400/E401 are the assistant's and anaesthetist's after-hours premiums, not yours (GP87, GP95).

Also bill, if it's true

Z606A	Did a cystoscopy today The consult doesn't include endoscopy (A207). Add E codes from the Office cystoscopy tile if you did more.	\$77.00
G900A	Post-void residual by ultrasound Not with a pelvic ultrasound, G192A–G194A, or a cystometrogram (J115).	\$12.70
G475A	Uroflow or cystometrogram with interpretation J115.	\$23.75
A355A	Also the referral consult (decided on cystoscopy today) Payable with the cystoscopy when this is the decision visit (SP4 §13).	\$93.15
A354A	Also a brief assessment before the procedure Partial assessment. The only visit allowed before a planned Z-code procedure when you decided on it at an earlier visit (SP4 §13).	\$30.60
E776A	Bladder biopsy or upper-tract brush biopsy One side (T7).	\$26.70
E781A	Fulgurated bladder tumour(s) T7.	\$53.50
E789A	Removed a foreign body or stone T7.	\$106.85
E790A	Removed a ureteric catheter T7.	\$9.45
E817A	Retrograde pyelogram, one side Catheterized the ureter and injected contrast (T7).	\$16.45
E818A	Inserted a ureteric stent, one side Past an obstructing lesion: E773A (\$53.50) instead, not both (T7).	\$26.70
E782A	Electrocoagulated a Hunner ulcer T7.	\$53.50
E775A	Catheterized the ureter for a ureteral urine sample One side (T7).	\$16.45
E824A	Bladder biopsy under general anaesthetic T7.	\$53.45
E784A	Hydrodistention under general anaesthetic T7.	\$53.45
E777A	Cystometrogram at the cystoscopy May include urethral pressure profile (T7).	\$12.35
E751A	Instilled chemotherapy through the scope Not with Z603A or Z611A (T7).	\$58.65
E791A	Periurethral bulking injection Only with Z606A; once per 16 weeks (T7).	\$50.70
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for day surgery; not if the hospital pays you for in-patient work (GP42).	+30%
E083A	You're the MRP +30% on MRP subsequent visits. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).	+30%
A355A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2). Nothing else before a Z-code procedure that day.	\$93.15
A354A	Brief assessment before a planned Z-code procedure Decision visit was in the last 12 months (SP4 §13).	\$30.60
E760A	Removed a stone T4.	\$174.55
E761A	Laser or other intracorporeal lithotripsy T4.	\$100.75

E822A	Went to the upper third of the ureter or renal pelvis T4.	\$39.60
E819A	Also scoped the second ureter T4.	\$54.65
E792A	Done laparoscopically or robotically +25% (T2, U8).	+25%
E766A	With gland dissection To nephrectomy (T2).	\$29.70
E820A	Biopsied the ureter or renal pelvis through the scope One or more sites (T4).	\$53.35
E823A	Resected or fulgured ureteral or renal pelvic tumour(s) One or more (T4).	\$250.50
G372A	Injection with the visit (e.g. LHRH agonist) Each intramuscular or subcutaneous injection (J54).	\$4.55
E676A	BMI over 40, general anaesthetic +25%, once per patient. BMI charted; open or laparoscopic pelvic or retroperitoneal surgery (SP6–SP7).	+25%
A355A	Consult that led to this surgery Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).	\$93.15
A353A	Assessed your own patient before the surgery Specific assessment (SP2 §2).	\$51.45
E783A	Evacuated bladder clots and controlled bleeding T7.	\$106.80
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of this procedure and any procedure ticked below (GP104).	+50%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the consult (GP103–GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of this procedure and any procedure ticked below (GP104).	+75%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the consult (GP103–GP104).	+75%
G700A	Uroflow, cystometrogram or prostatic massage was the only reason for the visit Only with G475A or G476A, the urology procedures marked (+). Once per visit, not in hospital, not with a consult or assessment (J3, J115).	\$8.80
K036A	Filled in the Northern Health Travel Grant form Specialist's part of the form; payable to the referring doctor and the specialist (A60).	\$10.25
K070A	Home care referral form to Ontario Health atHome You're the MRP giving ongoing care (e.g. catheter care at home). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K730A	Phoned another specialist for advice about this patient You're the referring doctor; 10+ minutes, start and stop times charted. Not to arrange a referral, a transfer or to discuss test results. Paid on top of today's visit; 1 per patient per day (A42–A44).	\$37.05
K738A	Sent an e-consult to another specialist You're the referring doctor; secure e-consult, answered within 30 days. Paid on top of today's visit; 1 a day, 6 per patient per 12 months (A48–A49).	\$16.45
K121A	In-patient case conference Per 10-minute unit (10, 16, 26, 36 min...). Pre-scheduled, with the MRP plus 2+ other physicians or regulated professionals; chart start/stop, participants and outcome. Paid with today's visit, as long as the visit was done outside the conference. Max 4 per patient per 12 months, 8 units a day (A31–A33).	\$37.05

Did a procedure?

S626A + E545A	Vasectomy in the office E545A only outside hospital (U6).	\$128.85
Z712A	Prostate biopsy, transrectal	\$91.60
Z712A + E821A	Prostate biopsy, transperineal U8.	\$111.60
Z611A	Catheterization, office or hospital Acute retention, Foley/SP tube change or instillation only; not with a surgical procedure (T8).	\$9.15
Z603A	Catheterization at home Same conditions as Z611A (T8).	\$16.25
G869A	Botox injection of the bladder detrusor Refractory overactive bladder after 3+ months of behavioural or anticholinergic treatment. All injections of one treatment; 1 per 12 weeks. Z606A is paid on top if you scoped (J51).	\$150.00
Z610A	BCG or chemo instillation for bladder cancer Done personally; no Z611A on top (T8).	\$25.65
Z608A	Catheter declotting and bladder irrigation	\$58.65
Z621A	Urethral stricture dilatation, male, local	\$20.60
Z622A	Urethral dilatation, female Not with a cystoscopy (T6).	\$10.60
Z615A	Filiforms and followers May include catheterization.	\$64.05
Z617A	Urethroscopy, diagnostic	\$38.05
Z618A	Urethroscopy with biopsy T10.	\$83.30
G373A	Injection was the only reason for the visit (e.g. LHRH agonist) First injection; each extra one is G372A (\$4.55). Not with an assessment (J54).	\$7.90
Z616A	Urethral biopsy, no scope	\$25.25
Z708A	Hydrocele aspiration	\$21.20
Z709A	Scrotal abscess or haematocoele drained, local	\$42.45
Z700A	Intracorporeal injection for ED	\$27.80
Z701A	Penile warts, local	\$34.95
Z702A + E542A	Penile biopsy	\$55.10
S569A	Dorsal slit, adult or child	\$65.30
G193A	Complete multichannel urodynamics	\$43.85
G193A + G194A	Multichannel urodynamics with EMG	\$52.20
G192A	Video urodynamics With interpretation.	\$73.65
Z600A	Nephrostomy tube change	\$44.00
Z101A + E542A	Skin abscess drained, local One. Two: Z173A (\$33.25); three or more: Z174A (\$44.70), + E542A (M1).	\$40.85

Can I bill these together?

Code	With	Together ?	Why
E078A	A353A, A354A	No	E078A is only paid to the specialties listed in GP25; Urology (35) isn't one of them (GP25).
A355A,A935A,C355A,C935A	Z606A, Z607A, Z712A, Z628A, Z632A, Z633A, Z617A, Z618A, Z621A, Z615A, Z616A, Z608A, Z700A, Z701A, Z702A, Z708A, Z709A, Z600A	Yes	The consult where you decide on the procedure is the major pre-op visit, and it is paid with the procedure done the same day; the consult doesn't include endoscopy. No second assessment before it that day (SP4 §13, GP4, A207).
A356A,A353A	Z606A, Z607A, Z712A, Z628A, Z632A, Z633A, Z617A, Z621A	Sometimes	Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A354A) is payable before it that day (SP4 §13).
A354A	Z606A, Z607A, Z712A, Z617A, Z618A, Z621A, Z622A, Z615A, Z616A, Z608A, Z610A, Z611A, Z603A, Z600A, Z700A, Z701A, Z702A, Z708A, Z709A, Z628A, Z632A, Z633A	Yes	A partial assessment is allowed with a Z-code procedure, even one planned at an earlier visit (SP4 §13). Unlike the consult and specific assessment, A354A doesn't include catheterization (A207); Z611A/Z603A only for acute retention, a catheter or SP tube change, or instillation (T8).
K731A,K739A	A355A, A935A, A356A, A353A, A354A, C355A, C935A, C356A, C353A, C354A	No	The consultant side of a phone or e-consult isn't paid if you also see the patient (consult, assessment or visit) that day or the next (A43, A49).
G869A	Z606A	Yes	Z606A is paid with bladder Botox G869A when you scope (J51).
G700A	A355A, A935A, A356A, A353A, A354A, C355A, C935A, C356A, C353A, C354A	No	G700A is only for a visit where the procedure was the sole reason; not with a consult or assessment the same day, and not in hospital (J3).
Z611A,G476A	A355A, A356A, A353A	No	The urology consult and specific assessment include catheterization and prostatic fluid exam when needed (A207 note).
Z611A	Z606A, Z607A, Z712A, Z628A, S626A, Z632A, Z633A	No	Z611A is not paid with any surgical procedure (T8).
Z611A,Z603A	Z610A, E751A	No	Catheterization is included in Z610A and isn't paid with E751A (T7, T8).
Z606A	Z632A, Z633A, Z634A	No	No additional claim for cystoscopy when bladder tumours are excised (T8).
Z606A	Z607A	No	Z607A is the repeat within 30 days; one cystoscopy code per scope (T7).
Z606A	E776A, E781A, E789A, E817A, E818A, E783A, E777A	Yes	E add-ons are paid on top of the bladder S and Z codes (T6 §4).
E791A	Z607A, Z628A, Z632A	No	E791A is only paid with Z606A (T7).
E773A	E818A	No	Only one of E773A or E818A for the same ureteric obstruction (T7).
Z628A	E760A, E761A, E822A, E819A	Yes	Ureteroscopy add-ons are paid on top of Z628A (T4).
G900A	G475A	Sometimes	Yes with a uroflow study; not when G475A is a cystometrogram or voiding pressure study (J115).
G900A	G192A, G193A, G194A	No	G900A is not paid with G192A–G194A (J115).
S626A	E545A	Yes	E545A is the out-of-hospital add-on to the vasectomy (U6).
S651A	S636A, S519A, S626A	No	Radical prostatectomy includes vesiculectomy, bladder neck repair and vasectomy (U8).

Code	With	Together ?	Why
Z786A	S565A	No	Z786A is not paid if a shunt or other penile surgery follows for the same priapism episode (U1).
Z615A	Z619A, Z620A, Z621A, Z622A	No	Z619A, Z620A, Z621A and Z622A are paid at nil when claimed with Z615A (T11).
G373A	A355A, A356A, A353A, A354A	No	G373A is for an injection that was the only reason for the visit. With an assessment, bill G372A (J54).
C142A, C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).
C122A	C124A, C126A, C352A	No	One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).
E083A	C358A	No	E083A is only for the MRP's own subsequent visits (GP47).
E084A	C352A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Urology isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026); pages in brackets. Totals are your fee only (suffix A): the surgical assistant bills the Asst units × \$12.91 and the anaesthetist the Anae units × \$15.96, plus time units, with suffix B or C (GP85, GP92). Totals leave out the 85% rule for a second non-Z procedure under the same anaesthetic (SP2) and any procedure entered outside the procedure list. Age premiums for patients under 16 on consults and surgery are added by OHIP on the remittance (GP64).

Fees are the Ontario Schedule of Benefits amounts and may change. Billing codes, rules and rejections for every code: verismo-apex.com/resources/billing.